STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF INSPECTOR GENERAL
OFFICE OF HEALTH FACILITY LICENSURE AND CERTIFICATION

Earl Ray Tomblin
Governor

Karen L. Bowling
Cabinet Secretary

Long-Term Care Nurse Aide Program

SOCIAL SECURITY NUMBER DISCLOSURE: Disclosure of your social security number should only be made if obtained from you in accordance with Section 7 of the Privacy Act of 1974. Your disclosure is voluntary for the purpose of internal identification, and may be used to verify information on your application, (class admissions and completions, competency evaluation testing, re-registration and reciprocity applications, etc), to verify certification with another state's certification authority, for exam identification, for identification purposes in national disciplinary databases or as the basis of a disciplinary action against you.
In accordance to the 42CFR 483.156(c), failure to provide requested information may result in your application being returned, a delay in processing, or your name not being placed on the West Virginia Nurse Aide Registry.

Applicant Information

If you have a name change due to marriage or divorce, attach a photocopy of the legal document, i.e., marriage certificate, divorce decree.

Full Name: _____ Birthdate: _____
Last *First* *M.I.*

Address: _____
Mailing Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: **( ) -**

Social Security #: - -

Registration number: _____

Due to re-register: _____

Have you ever been convicted, plead guilty to, or plead no contest to a misdemeanor involving a child or incapacitated adult?	YES ☐	NO ☐	If yes, attach legal documentation.
Have you ever been fired from a job due to an allegation of abuse, neglect, or misappropriation of resident's property?	YES ☐	NO ☐	If yes, attach a brief description:
Have you ever been convicted of a felony, plead guilty to or plead no contest to a felony punishable up to one year or more?	YES ☐	NO ☐	If yes, attach legal documentation.
Have you ever been convicted of a felony, in any state, that has NOT been previously reported to this Nurse Aide Registry (NAR)?	YES ☐	NO ☐	If yes, attach legal document
Do you have any criminal charges currently pending in any state, which have **NOT** been previously reported to this NAR?	YES ☐	NO ☐	If yes, attach a brief description: (what, when and where)
Are there disciplinary actions pending against you, or your placement on any NAR, in any state, that has **NOT** been reported to this Agency?	YES ☐	NO ☐	If yes, attach a brief description: (what, when and where)

Current Job Experience

*Please list where you are **currently** working.*

CURRENT Employer: _____ Date Hired: __/__/__

Address: _____ Phone: **( ) -** _____

Responsibilities:

☐ Feeding ☐ Vital Signs ☐ ADL's ☐ Bed making ☐ Catheter care
☐ Activities ☐ Height/Weight ☐ Laundry ☐ Transfer/lifting ☐ Transporting

***** Previous Work Experience (List in chronological order) *****

Please list your paid nurse aide related work history for the <u>past three (3) years</u>. Independent (Self-employed) private duty work experiences are no longer reportable, as of July 1, 2006.

Facility/Employer: ______________________________ Phone: ( ) -

Address: ______________________________ ______________________________

Responsibilities: ☐ Feeding ☐ Vital Signs ☐ ADL's ☐ Bed making ☐ Catheter care
☐ Activities ☐ Height/Weight ☐ Laundry ☐ Transfer/lifting ☐ Transporting

From: ___/___/___ (Mo/Day/Yr) To: ___/___/___ (Mo/Day/Yr)

Facility/Employer: ______________________________ Phone: ( ) -

Address: ______________________________ ______________________________

Responsibilities: ☐ Feeding ☐ Vital Signs ☐ ADL's ☐ Bed making ☐ Catheter care
☐ Activities ☐ Height/Weight ☐ Laundry ☐ Transfer/lifting ☐ Transporting

From: ___/___/___ (Mo/Day/Yr) To: ___/___/___ (Mo/Day/Yr)

Facility/Employer: ______________________________ Phone: ( ) -

Address: ______________________________ ______________________________

Responsibilities: ☐ Feeding ☐ Vital Signs ☐ ADL's ☐ Bed making ☐ Catheter care
☐ Activities ☐ Height/Weight ☐ Laundry ☐ Transfer/lifting ☐ Transporting

From: / / (Mo/Day/Yr) To: / / (Mo/Day/Yr)

Facility/Employer: ______________________________ Phone: ( ) -

Address: ______________________________ ______________________________

Responsibilities: ☐ Feeding ☐ Vital Signs ☐ ADL's ☐ Bed making ☐ Catheter care
☐ Activities ☐ Height/Weight ☐ Laundry ☐ Transfer/lifting ☐ Transporting

From: / / (Mo/Day/Yr) To: / / (Mo/Day/Yr)

An incomplete application will be returned for further information, and will delay the registration processing. Submitting false information will result in the loss of your eligibility status on the registry.

Disclaimer and Signature

I certify that my answers are true and complete. By signing this application, I understand that false or misleading information on my application will result in the removal of my name from the West Virginia Long-Term Care Nurse Aide Registry.

Signature: ______________________________ Date: ______________________________

MAIL APPLICATION TO: NURSE AIDE PROGRAM
OFFICE OF HEALTH FACILITY LICENSURE AND CERTIFICATION
408 LEON SULLIVAN WAY
CHARLESTON, WV 25301-1713
TELEPHONE: (304) 558-0050 FAX (304) 558-1442

07/2013- revised